

## Physical Therapy Case History

### General Information:

	/ /		M / F
Patient's name	D.O.B.	Age	Gender

		/ /
Person Providing Information	Relationship to Patient	Date
Address:		
Apt:		
City: State: Zip Code:		
Phone Number:		

Does the child live with both parents? YES / NO

Mother's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Primary Insurance:
I.D. #
Group #
Phone #

Secondary Insurance:
I.D. #
Group #
Phone #

Emergency Contact	Phone #
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Referred by:

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Primary Care Physician:

Referred For: Physical Therapy / Occupational Therapy / Speech Therapy

Does the patient have any brothers or sisters? YES / NO

(If yes, please include names and ages.)

Sibling's Name	Sibling's Age

Birth History

Age of mother at the time of birth: \_\_\_\_\_ Length of pregnancy: \_\_\_\_\_

Birth weight: \_\_\_\_\_ Type of delivery: \_\_\_\_\_ vaginal \_\_\_\_\_ cesarean

Pregnancy or delivery complications: \_\_\_\_\_

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NICU stay? If yes, how long: \_\_\_\_\_

Developmental History

Please tell the approximate age your child achieved the following developmental milestones (approximately):

played on tummy \_\_\_\_\_ rolled over \_\_\_\_\_ crawled \_\_\_\_\_ sat alone \_\_\_\_\_  
pulled to stand \_\_\_\_\_ stood alone \_\_\_\_\_ walked alone \_\_\_\_\_



Medical History

Has your child had any of the following?

Hospitalizations/reason:

\_\_\_\_\_

Please list any medications your child is currently taking: \_\_\_\_\_

\_\_\_\_\_

Please list any food or drug allergies: \_\_\_\_\_

Therapy History

- |                           |                    |                      |
|---------------------------|--------------------|----------------------|
| _____adenoidectomy        | _____encephalitis  | _____seizures        |
| _____allergies            | _____head injury   | _____sleeping issues |
| _____breathing difficulty | _____high fevers   | _____tonsillectomy   |
| _____chicken pox          | _____measles       | _____tonsillitis     |
| _____ear infections       | _____mumps         | _____torticollis     |
| _____how many_____        | _____rubella       | _____which side_____ |
| _____ear tubes            | _____scarlet fever |                      |

When did you first notice a problem/history of current concern? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Diagnosis (if known): \_\_\_\_\_

Has your child ever received, or is currently receiving, any other special services (occupational therapy, speech therapy, specialized physician, special tests, early intervention, imaging): \_\_\_\_\_

\_\_\_\_\_

School History (if applicable)

Grade level: \_\_\_\_\_

Special services received at school: \_\_\_\_\_

Additional Comments:

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**CONSENT TO TREATMENT**

I hereby consent to ACROSS THE BOARD THERAPY, LLC, to furnish therapy services to \_\_\_\_\_ as prescribed by the physician. I hereby authorize payment directly to ACROSS THE BOARD THERAPY, LLC, of the individual or group insurance benefits specified and otherwise payable to me. I understand I am fully responsible to ACROSS THE BOARD THERAPY, LLC, for all charges not paid by my insurance provider. ACROSS THE BOARD THERAPY, LLC, is authorized to release to said insurance companies, to Transworld Systems, Inc. any/all information listed above and/or medical records.

**Name of Patient:** \_\_\_\_\_

**Signature of Parent:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**If applicable, Legal Representatives sign below:**

*By signing this form, I represent that I am the legal representative of the Patient identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Patient's behalf with respect to this authorization form.*

**Name of Legal Representative:** \_\_\_\_\_

**Signature of Legal Representative:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Name of Witness:** \_\_\_\_\_

**Signature of Witness:** \_\_\_\_\_



**Across the Board Therapy Group LLC**  
**Policies**

**Attendance.**

At Across the Board Therapy Group, scheduled appointments are a bond between our therapists and our patients. This is our opportunity to provide the highest standard of care to each patient. To help us honor our commitment to your care, we ask all families to follow a few simple guidelines:

1. Arrive for your appointment on time
2. Provide at least a twenty four (24) hour notice for cancellations
3. Limit number of cancellations
4. Honor our bond

We realize that emergencies happen and schedules change. However, appointments that were habitually missed, cancelled, or changed will result in one of the following actions:

1. Loss of your regular appointment time
2. Reduction in number of weekly appointment
3. Discharge from this facility as a result of poor attendance

If we feel attendance patterns are habitually not meeting our expectations, we reserve the right to initiate the above procedures at our discretion. No show appointments will result in a \$25.00 charge. That charge is not covered by insurance and will be the responsibility of the guarantor on the account. Failure to pay the charge will result in discharge from this facility. Cancellations at or during your scheduled therapy session are considered a no show.

**Illness.**

If your child is sick please do not bring him/her to therapy until they are sufficiently well. Some of our patients may be medically fragile, therefore, do not bring sick siblings in the Clinic either.

**Payment.**

Unless other arrangements have been made, payment is due at the time of the service. Medical records will not be released if there is an outstanding balance.

**Clinic.**

Parents are to remain at the Clinic during their child's services. If it is necessary to leave, the parents must provide a phone number where they can be reached. Typically pediatric sessions are every 30 minutes, therefore, parents are asked to be present five (5) minutes prior to the end of the session to discuss their child's progress and home activities.

**Name of Patient:** \_\_\_\_\_

**Signature of Parent:** \_\_\_\_\_

**Date:** \_\_\_\_\_

***By signing this form, I represent that I am the legal representative of the Patient identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Patient's behalf with respect to this authorization form.***

**Name of Legal Representative:** \_\_\_\_\_

**Signature of Legal Representative:** \_\_\_\_\_



Date: \_\_\_\_\_

**CONSENT TO RELEASE INFORMATION**

Patient's Name:	
Patient's Date of Birth:	
Patient's Address:	
Patient's Biological Parents' Names or Legal Guardian:	

**I authorize Across The Board Therapy, LLC, to release and/or obtain information about the above patient from:**

Patient's Primary Care Physician:	Address:	Telephone:	Facsimile:
Insurance Company:	Policy Number:	Address:	Telephone:
School District:	Address:	Telephone:	Facsimile:
Teacher:	Address:	Telephone:	Facsimile:
Other:	Address:	Telephone:	Facsimile:

Signature of Parent: \_\_\_\_\_  
Date: \_\_\_\_\_

*By signing this form, I represent that I am the legal representative of the Patient identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Patient's behalf with respect to this authorization form.*

Name of Legal Representative: \_\_\_\_\_

Signature of Legal Representative: \_\_\_\_\_

Date: \_\_\_\_\_

Name of Witness: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_

## Notice of Privacy Practices How Your Medical Information Is Used

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Notice applies to ACROSS THE BOARD THERAPY GROUP, LLC (“ACROSS THE BOARD”). ACROSS THE BOARD will use and distribute this Notice as its Notice of Privacy Practices and follow the information practices described in this Notice when using or disclosing records and information. It will share your health information as allowed and necessary, to carry out treatment, payment, or health care operations as described in this Notice.

### Understanding Your Health Information

Each time you visit a hospital, clinic, physician, or other health care provider, a record of your visit is made. Typically, this health record contains your medical history, symptoms, examination and test results, diagnosis, treatment, care plan, insurance, billing, and employment information. This health information, often referred to as your health record, serves as a basis for planning your care and treatment and is a vital means of communication among the many health professionals who contribute to your health care. Your health information is also used by insurance companies and other third-party payers to verify the appropriateness of billed services.

### Our Responsibilities

We are required by law to:

- Maintain the privacy of your health information during your lifetime and for years following your death.
- Provide you with an additional current copy of our Notice upon request.
- Abide by the terms of our current Notice.
- Notify you following a breach of unsecured protected health information in the event you are affected.

We will not use or disclose your health information without your written authorization, except as described in this Notice.

### Uses And Disclosures Without Your Written Authorization

*We may use and disclose your health information without your written authorization for Treatment, Payment and Health Care Operations*

*We will use and disclose your health information for treatment purposes*

For example: Information obtained by a nurse, physician or other member of your health care team will be recorded in your record and used to determine the course of treatment. Health care team members will communicate with one another personally and through the health record to coordinate care provided. We will also provide your physician or subsequent health care provider with copies of various reports that

should assist him or her in treating you in the future.

***We will use and disclose your health information for payment purposes***

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. We may disclose health information about you to other qualified parties for their payment purposes. For example, if you are brought in by ambulance, we may disclose your health information to the ambulance provider for its billing purposes.

***We will use and disclose your health information for health care operations***

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of health care we provide. In some cases, we will furnish your health information to other qualified parties for their health care operations. The ambulance company, for example, may want information regarding your condition to help them know whether they have done an effective job of stabilizing your condition.

***Health Information Exchange***

We may make your protected health information available electronically through an information exchange service to other health care providers, health plans and health care clearinghouses that request your information. Participation in information exchange services also lets us see their information about you.

***Teaching***

Residents, fellows, and students in medicine, therapy, allied health and graduate studies, may be assisting with your care under the supervision of a licensed health care provider as a part of their professional health care training program.

**Other Uses and Disclosures of your health information Without your Written Authorization**

***Notification***

We may use or disclose health information to notify or assist in notifying a family member, personal representative, or another person responsible for your care of your location and general condition.

***Communication With Family and Others***

We may disclose relevant health information to a family member, friend, or other person involved in your care. We will only disclose this information if you agree, are given the opportunity to object and do not, or if in our professional judgment, it would be in your best interest to allow the person to receive the information or act on your behalf.

***Directory***

Unless you notify us that you object, or we are otherwise prohibited by law, we may use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy, and, except for religious affiliation, to other people who ask for you by name.

***Business Associates***

There are some services provided in our organization through contracts with business associates. When these services are contracted, we may disclose your health information to our business associates so that they can perform such services. However, we require the business associate to appropriately safeguard your information.

***Appointment Reminders***

We may contact you as a reminder that you have an appointment for treatment or medical care.

***Treatment Alternatives***

We may contact you about treatment alternatives or other health-related benefits and services that may be of interest to you.

***Fundraising***

We may use and disclose your health information to our business associates and affiliated foundations for fundraising purposes. We may contact you in an effort to raise money for clinical programs, research and education. If you do not want us to contact you for fundraising efforts, you must notify ACROSS THE BOARD immediately.

***Public Health***

We may disclose health information about you for public health activities. These activities may include disclosures:

- To a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability;
- To appropriate authorities authorized to receive reports of abuse and neglect;
- To FDA-regulated entities for purposes of monitoring or reporting the quality, safety or effectiveness of FDA-regulated products; or
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- With parent or guardian permission, to send evidence of required immunizations to a school.

***Workers' Compensation***

We may disclose health information to the extent authorized and necessary to comply with laws relating to workers' compensation or other similar programs established by law.

***Correctional Institutions***

If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose to the correctional institution, its agents or the law enforcement official your health information necessary for your health or the health and safety of other individuals.

***Law Enforcement***

We may disclose your health information for law enforcement purposes:

- At the request of a law enforcement official and in response to a subpoena, court order, investigative demand or other lawful process;
- If we believe it is evidence of criminal conduct occurring on our premises;
- If you are a victim of crime and we obtain your agreement, or under certain circumstances, if we are unable to obtain your agreement;
- To identify or locate a suspect, fugitive, material witness or missing person;
- To alert authorities that a death may be the result of criminal conduct;
- To report a crime, the location of the crime or victim, or the identity, description or location of the person who committed the crime.

***Health Oversight Activities***

We may disclose health information for health oversight activities authorized by law. For example, oversight activities include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

***Threats to Health or Safety***

Under certain circumstances, we may use or disclose your health information if we believe it is necessary to avert or lessen a serious threat to health and safety and is to a person reasonably able to prevent or lessen the threat or is necessary for law enforcement authorities to identify or apprehend an individual involved in a crime.

### ***Specialized Government Functions***

We may disclose your information for national security and intelligence activities authorized by law, for protective services of the president; or if you are a military member, to the military under limited circumstances.

### ***As Required by Law***

We will use or disclose your health information as required by federal, State or local law.

### ***Lawsuits and Administrative Proceedings***

We may release your health information in response to a court or administrative order. We may also provide your information in response to a subpoena or other discovery request, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

### ***Funeral Directors, Medical Examiners, and Coroners***

We may disclose your health information to funeral directors, medical examiners, and coroners consistent with applicable law to carry out their duties.

### ***Organ Procurement Organizations***

Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

### ***Incidental Uses and Disclosures***

There are certain incidental uses or disclosures of your health information that occur while we are providing services to you or conducting our business. For example, after surgery the nurse or doctor may need to use your name to identify family members that may be waiting for you in a waiting area. Other individuals waiting in the same area may hear your name called. We will make reasonable efforts to limit these incidental uses and disclosures.

## **Uses And Disclosures That Require Your Written Authorization**

The following uses and disclosures will only be made with your written authorization:

- Uses and disclosures not listed above as permitted without your written authorization;
  - most uses and disclosures of psychotherapy notes;
  - uses and disclosures for our marketing purposes; and
  - disclosures that constitute a sale of your health information.

Your authorization may be revoked in writing at any time except with respect to any actions we have taken in reliance on it.

## **Your Health Information Rights**

You have the following rights regarding your health information:

### ***Right to Inspect and Copy***

You may request to look at your medical and billing records and obtain a copy. You must submit your medical records request to the Health Information Management Department. Contact the office listed on your billing statement to request a copy of your billing record. If you ask for a copy of your records, we may charge you a copying fee plus postage. If we maintain an electronic health record about you, you have the right to request your copy in electronic format.

### ***Right to Request Amendment***

You may request that your health information be amended if you feel that the information is not correct. Your request must be in writing and provide rationale for the amendment. Please send your request to the Health Information Management Department. We may deny your request, and will notify you of our decision in writing.

***Right to an Accounting of Disclosures***

You may request an accounting of certain disclosures of your health information showing with whom your health information has been shared (does not apply to disclosures to you, with your authorization, for treatment, payment or health care operations, and in certain other cases). To request an accounting of disclosures, you must send a written request to Across the Board. Your request must state a time period that may not be longer than six years.

***Right to Request Restrictions***

You may request restrictions on how your health information is used for treatment, payment or health care operations or disclosed to certain family members or others who are involved in your care. We may deny your request with one exception. If we agree to a voluntary restriction, the restriction may be lifted if use of the information is necessary to provide emergency treatment. We are required to agree to your request that we not disclose certain health information to your health plan for payment or health care operations purposes, if you pay in full for all expenses related to that service prior to your request and the disclosure

is not otherwise required by law. Such a restriction will only apply to records that relate solely to the service for which you have paid in full. If we later receive an authorization from you dated after the date of your requested restriction which authorizes us to disclose all of your records to your health plan, we will assume you have withdrawn your request for restriction. To request a restriction, you must send a written request to Across the Board, specifying what information you wish to restrict and to whom the restriction applies. You will receive a written response to your request.

***Right to Request Private Communications***

You may request that we communicate with you in a certain way in a certain location. You must make your request in writing to the patient registration staff and explain how or where you wish to be contacted.

***Right to a Paper Copy of this Notice***

You may request an additional paper copy of this Notice at any time.

**Complaints**

You may complain to us or to the Secretary of Health and Humana Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objection to this form, please ask us to explain. Signature below confirms acknowledgment of our Privacy Practices

***We reserve the right to change this Notice as our privacy practices change and to make the new provisions effective for all health information we maintain.***

**Name of Patient:** \_\_\_\_\_

**Signature of Patient:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**If applicable, Legal Representatives sign below:**

***By signing this form, I represent that I am the legal representative of the Patient identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Patient's behalf with respect to this authorization form.***

**Name of Legal Representative:** \_\_\_\_\_

**Signature of Legal Representative:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Name of Witness: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**HIPAA RELEASE OF INFORMATION  
AUTHORIZATION FORM**

I, \_\_\_\_\_ hereby authorize ACROSS THE BOARD THERAPY GROUP, LLC, and its affiliates, its employees and agents (collectively “ACROSS THE BOARD”), to release to \_\_\_\_\_ my personal health information maintained by ACROSS THE BOARD (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. This authorization is valid from the date of my/my representative’s signature below and shall expire on the date my coverage ends with ACROSS THE BOARD.

I understand that I have a right to revoke this authorization by providing written notice to ACROSS THE BOARD. However, this authorization may not be revoked if ACROSS THE BOARD, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Name of Patient: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_

Date: \_\_\_\_\_

**If applicable, Legal Representatives sign below:**

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Name of Legal Representative: \_\_\_\_\_

Signature of Legal Representative: \_\_\_\_\_

**Date:** \_\_\_\_\_  
**Name of Witness:** \_\_\_\_\_  
**Signature of Witness:** \_\_\_\_\_